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MONTANA COMPREHENSIVE HEALTH PLANNING NEWS

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Rural Health Still Lags Says Bd. Chairman

Rural medical services have been deteriorating steadily for the better part of a century although the myth has arisen that they are constantly improving, according to Richard J. Margolis, Chairman of the Board of Rural Health, Housing Alliance and Rural America, Inc.

Margolis made the remarks in a paper presented at the First National Conference on Rural America sponsored by Rural America, Inc. this past April in Washington, D.C.

The paper cites "gross maldistribution of (health) personnel" as being at the heart of the rural health crises.

Considerable blame for this maldistribution problem is attributed to the nation's 115 medical schools which, the author claims, "continue to train too many city-bound specialists — especially surgeons — and not enough rural-bound general practitioners."

According to the paper, "medical school admissions policies tend to perpetuate the urban and suburban bias. Most medical students come from non-rural upper middle-class backgrounds; one out of every three is the son of a physician. According to a U.S. Public Health Service Study, only 18% of medical students come from towns of less than 5,000 persons although such towns account for 38% of the total populations."

Margolis did note several recent

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BUTTE AND SILVER BOW CO. FORM CITY-COUNTY HEALTH DEPT.

Butte and Silver Bow County will soon be establishing a new city-county health department intended to coordinate health services in the county.

After more than six months of study, the Butte-Silver Bow County Health Board decided in May to bring all the public health programs together under the city-county health department.

Board Chairman, Dr. Robert Thometz, who has been instrumental in the development of the department, recommended that a professional health administrator be appointed to serve as head of the department.

For the past year, the Board has been seeking a doctor to serve as county health officer but was unsuccessful.

Jim Foley, Director of the Southwestern Areawide Health Planning Council, and Bob Ferran, Health Planner, conducted a feasibility study comparing the advantages of having a multi-county health department with those of a city-county department.

During a six-month period, Ferran and Foley studied local health departments in Billings, Cascade County, and Missoula eliciting information on their staffing and operating patterns.

After considering the alternatives, the Board and planning committee chose to establish a city-county department.

According to Foley, the new department will contract with already-existing health service agencies such as school nurses, well-child clinics, family planning, public health nurses, sanitation department, venereal disease and tuberculosis programs to provide services.

Under such a plan, the services would remain autonomous but would be coordinated through the central office.

"What really made the plan go was the cooperation of all the people providing the services and the guidance of Dr. John Anderson, Director of the Department of Health and Environmental Sciences," Foley said.

In early May, the Board met with Don Pizzini, Great Falls City-County Health Officer, and Jon Tovson of the Great Falls department. Pizzini indicated that centralization of services could result in better supervision, accountability, and provision of services.

Foley also indicated that if the Board could remain the supervising agency, none of the currently existing programs with whom the department would contract would lose staff positions.

At the meeting, Bob Vivian, school board representative on the Board, indicated that the school board would have no objection to the nurses' receiving direction from the health department.

DEFENSIVE MEDICINE: DOCTOR VS. PATIENT?

Second in a Series on Medical Malpractice

One of the results of the present medical malpractice crisis is the so-called practice of "defensive medicine." Charges as well as admonitions have been made that doctors are altering ascribed-to patterns of practice due to the threat of malpractice litigation.

Consequently it has also been charged that patients are suffering from a lower yet more expensive level of care because of the practice of defensive medicine.

But what exactly is "defensive medicine," who practices it, and why?

So far there is no real agreement on exactly how defensive medicine should be defined, and according to some sources there is no conclusive evidence that such practices do indeed exist. Nevertheless, many physicians are asserting that they are in fact — for the betterment or the deprivation of the patient — altering their modi operandi out of fear of liability.

What Is Defensive Medicine?

Defining lends itself to interpretation, and any given definition could well be disputed. Yet one definition which has proven somewhat workable has been offered by a Duke Law Journal study. The study divides defensive medicine into two categories: "positive" and "negative" defensive medicine.

Positive defensive practice is when a physician **performs** tests or procedures because he or she fears that if they are not performed and the patient suffers a bad result, then someone might be able to testify that the procedure could have prevented the undesirable outcome.

Negative defensive medicine on the other hand, is defined by Duke as a practice wherein a procedure is not performed because the risk of a bad reaction is feared, even though the physician believes the procedure to be a proper one.

In essence then, the negative practice is an avoidance of the patient and his condition probably because they have been statistically shown to be risky in bringing lawsuits.

Although the definition makes a distinction between positive and negative, it still begs the question of whether or not either type of defensive practice is necessarily good or poor medical practice.

Poor practice, it is commonly agreed, is that which results in poor quality care for the patient and unreasonable cost. But then again, what is poor quality care?

Defensive vs. Quality

Admittedly, doctors often perform more procedures and tests than are deemed necessary; and these do up the cost to the patient. Among those procedures were ones mentioned in the HEW's Commission on Medical Malpractice's report as occurring most frequently:

Excessive use of X-ray and routine diagnostic procedures;

Excessive utilization of laboratory tests;

Additional office visits as follow-up to conditions which might prove to have complications;

Increased instances of hospitalization on borderline cases;

Extended hospitalization after surgery to avoid complications at home.

There is considerable disagreement over whether such practices are poor quality medical care or in fact just the opposite.

For example, this question was posed to 17 physicians in the Pittsburgh, Pennsylvania area who consented to partake in a study conducted by Nathan Hershey and published in the **Milbank Memorial Quarterly.**

For the purposes of the survey, "defensive medicine" was defined to represent poorer quality medical care. Typical of the responses was the statement, "I practice good medicine, and that is it."

This seems to indicate that while certain procedures may seem excessive or unnecessary for one physician, a good number of other doctors might consider them to be essential to good practice. In general, it has been concluded that it is probably impossible to determine where the line should be drawn between "good" and "bad" defensive practice.

However, one thing that is certain is that a good number of doctors are conceding that the threat of liability is having an effect upon their practice.

How Extensive?

According to an American Medical Association survey, over 70% of the responding doctors indicated that they did practice defensive medicine. Evidence from the Pittsburgh survey on the other hand, was not so overwhelming.

In the latter survey, a few of the doctors stated unequivically that threat of liability plays no part in their practice while others indicated that the threat was constantly present.

Nine of the seventeen interviewed indicated that they practice defensively to some extent. However, of those responding, the physicians who had had experience with malpractice litigation indicated that liability consideration plays a very minor role in their practice.

Still doctors concede that there are patients and circumstances of which they are becoming wary. Doctors have described as risky patients who are paranoid, hysterical or exhibiting other psychoneurotic tendencies, from a low socioeconomic background, or exhibiting a belligerent attitude.

Said one physician, "Sometimes you can almost smell trouble in certain people." While another stated, "Certain patients I won't operate on — I won't touch them with a ten foot pole — because if they don't get better, that could serve to jeopardize my relationship to them, and also lead to something like what we are talking about (litigation)."

Nevertheless, it should be noted that while some physicians claim that all or nearly all doctors prac-

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tice defensively, neither the Pennsylvania nor the Duke study have been able to show conclusively or statistically to what extent defensive medicine is actually practiced.

Hence, those who vocally affirm the practice of defensive medicine as wide-spread may represent only a minority of physicians.

And it still must be noted that although a particular doctor may be admittedly practicing with the fear of liability in mind, the defensive nature of his practice may as well be perfectly commensurate with the highest level of care he is capable of providing.

The Cost of Defensive Medicine

The question of whether or not the practice of defensive medicine has increased the cost of medical care to patients is something of a two-sided coin.

On the one hand, if defensive medicine results in unneeded and unwanted procedures, tests, etc., then the cost has adversely accelerated.

But when looked at in a different perspective, perhaps that increased cost can be viewed as directly proportional to the increased level of care which some claim defensive medicine affords.

For example, the Commission on Medical Malpractice revealed that some of those testifying cited the threat of possible litigation as possibly helping to improve the quality of care in a number of respects.

Examples of areas of care which might be improving according to the Commission report are:

Better emergency room treatment;

Better cardiac arrest procedures;

Reduction in the use of poorly-trained medical assistants;

More judicious use of potentially harmful drugs;

Better medical record keeping;

More widespread use of consultants in borderline diagnostic situations;

Better communication with patients and their families regarding proposed surgical procedures.

Of course there are other reasons as well for these improved services and practices not the least of which are improvements in diagnostic techniques and greater awareness of the patient as to the quality of medical care.

Still there are those who admit that a purely protective cost is being passed on to the consumer as one doctor has stated on behalf of defensive medicine, "If some S.O.B. patient can sue me for a million dollars, I ought to be able to give him a few hundred dollars worth of defensive X-rays to protect myself."

Despite the fact that there exist indications that doctors are generally ordering more tests than are necessary, the influence that the threat of medical malpractice litigation has on such a development is for the most part conjectural at this point.

As to the exact cost of defensive practice to the consumer, there does not seem to be any reliable estimate, although figures reaching as high as $5 billion per year have been offered.

Effect on the Physician-Patient Relationship

Another element of the defensive medical practice issue is the effects of such practice on the physician-patient relationship.

While there are some who contend that such relationships do not even exist, are as antiquated as the house-call, the Pittsburgh study found some interesting results when putting the question to the doctors.

The majority of those responding rated their relationships high, between 7.5 and 10 on a 10-point scale. Surprisingly enough, those physicians responding who had had malpractice suits or claims brought against them rated their relationships to be between 9.5 and 10.

The doctors interviewed said that they had heard or knew from first hand experience that the situation in Pennsylvania was far different than that in California where, they charged, relationships between doctors and patients border on open hostility and consequently the threat of liability weighs heavily upon doctors' conscious practice.

The third article in the series will deal with proposed solutions to the medical malpractice crisis—long-term and short-term.

Comings/ Goings

Leaving CHP in June was Cathy Campbell who has assumed the position of Family Planning Coordinator in the state. While at CHP, Ms. Campbell served as Facilities Health Planner since 1973.

One of Ms. Campbell's responsibilities at CHP was the 1122 Review and Comment duties governing health care facilities' modernization and expansion under the auspices of Section 1122 of the Social Security Act.

Ms. Campbell was also involved in the recently-passed Certificate of Need Legislation and the development of a data base for health statistics.

Cathy Campbell

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Gov. Declares Montana Single HSA

On May 2, Governor Thomas Judge recommended to the Secretary of Health, Education and Welfare that the State of Montana be designated a single health service area pursuant to directives outlined in the recently-enacted National Health Planning and Resources Development Act of 1974 (PL 93-641).

The Governor's recommendation necessitated by the long-awaited measure passed by the 93rd Congress shortly before adjourning last December, eliminates Comprehensive Health Planning and Regional Medical Programs replacing them with Health Systems Agencies (HSA's).

Between the time the new law was passed and the Governor's announcement, health-related organizations throughout Montana were asked by the Office of Budget and Program Planning to submit their recommendations on how the State should be divided into planning areas.

Eudy left and Dr. Bell

The law states that an area so designated must have a minimum population of 500,000 and a center for highly specialized services. An area seeking designation without fulfilling that criteria has to be considered for a waiver.

The Governor's request for a single area will preclude the need for such waivers being applied to Montana. The entire state's population is slightly more than 700,000 and there are a few facilities which could be considered as centers for highly specialized services.

On February 27, a meeting was held in Helena at which principal individuals in the health field had an opportunity to meet with the Governor's staff and express their views on the designation of health service areas.

In general, the comments offered at the meeting, which was not intended to result in any form of a consensus, were weighed toward advocating more than one health planning area in the State.

Stressing the importance of local input into health planning, representatives from the CHP areawide agencies and several of their volunteer board members called upon the group to recognize the potential for a continuation of local planning and accessibility to decision making.

Robert Bell, DVM, the Chairman of the Economic Development Association of Eastern Montana (EDAEM) which serves as the present parent agency for the Eastern CHP areawide said, "We've currently been working on a comprehensive health plan in Eastern Montana. The average cost to attend a meeting in District 1 is $20.50. The total driving time is 3.16 hours average, and the average miles driven to attend a meeting is 171.

"If you are talking about moving the planning headquarters three to four hundred miles farther away, I am telling you the people of Eastern Montana are not interested in getting farther away from planning; we want to get closer."

Agreeing with Dr. Bell was Rich Eudy, Health Planner for EDAEM, "Our planning district incorporates 17 counties, and I think that if the area is divided differently, it will lose total support of the people from Eastern Montana and any plan that is written will just be totally ignored."

Also speaking on behalf of five health areas was Jim Foley, Director of Southwestern Areawide Health Planning Council. "We now have a regional concept that doesn't have to do only with health planning.

"We have a regional mental health program, a regional alcohol program and a regional drug program. We feel that the number one priority is the rural health needs and we can establish that a lot better with five than any other way."

Ed Mahn, Director of the Northwestern Areawide Health Planning Council, advocated the designation of three areas saying, "We have looked at all the variables and recommend that three areas are the most practical in Montana given the guidelines of the federal government. Three regions follow the boundaries of the Emergency Medical Services districts, follow the natural trade barriers, each has a medical center, and they would require only one 'highly unusual circumstance' waiver."

Pratt: One area — superior forum

Some people in attendance indicated the advantages to having one health service area encompassing the entire state. Among those was Dr. Sidney Pratt, Director of the Mountain States Regional Medical Program.

"The advantage of one health service area would be the effective coordination of health planning and resource development, cost effectiveness, encouragement of objectivity in the assessment of health needs and concerns without paro-

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chialism becoming involved, and more cooperation and participation brought about by the development and staffing of sub-areas."

Dr. Pratt said that sub-areas which would be a possibility under one health area designation could provide the local input and added that long distances will have to be encountered despite the number of areas designated.

Pratt also stated, "One area will provide a superior forum for convening and facilitating exchange of information among the major health interest groups and institutions by having one central organization that people could go to instead of scattering around five, four, three or two areas."

Most people attending emphasized the need for continued local input and stressed that as much decision making as possible be done on a local level.

"Our group has gone really strong for the Governor's five planning areas, but whatever we have — one, three or five areas — please let's keep the decision making such as the 1122 reviews in the local area where people can have some say in how the money is spent in their area," said Ed Morse, who serves as volunteer Chairman of the North Central Montana Health Planning Council.

Jim Toner, Director of the South Central Montana Health Planning Council also expressed concern for local input, "People here know that if they don't understand something there is someone there who can cut through the red tape for them. They can understand their health system, they can begin working with their doctors. They don't want to lose what they've got," he said.

Toner: local input

Hulme: "Pursue the problems"

Responding to the comments, Dick Hulme of the Governor's Office stated that he could not address the specifics of health planning but noted, "If you split up the state by some process and put everybody in an area that has full services even though they may be miles away, you still haven't solved the health care problems of that area. The immediate thing that we might do is pursue the problems of Eastern Montana and Montana in general where there are long distances and lack of services."

Judy Carlson, State-Regional Coordinator in the Governor's Office also attended and stated that alternatives should be explored to insure maximum area-wide participation in the event that the federal government did not grant a request for a multi-area designation.

"The only thing that makes any sense at all is to maintain the existing five regions. If for any reason that that turns out to be unacceptable, then the only way to maintain the existing five regions is to have one state health systems agency with five sub-area councils with the idea of using that vehicle to maintain the existing structures we have."

Recommendations from those attending the meeting and others whose recommendations were sought revealed almost unanimous support for five areas from health planners, state agencies and local government.

The health providers were split between three areas and a statewide area. The facility operators associations (Hospital and Nursing Home Associations) preferred three areas and the Regional Medical Programs (RMP, IRMP) along with the Montana Medical Association preferred a single statewide area.

Support for three areas also came from the Northwestern Area-wide Health Planning Council, two county health departments, a hospital, and the Western Montana Medical society.

Carlson — maintain what we have

The National Level

Since the inception of Professional Standards Review Organizations within the framework of the 1972 Social Security Amendments, the PSRO amendment has been a matter of controversy particularly among provider groups such as the American Hospital Association, American Medical Association, and the Association of American Physicians and Surgeons.

This past May, a panel composed of three federal judges ruled in Chicago that Congressional action establishing PSRO's as a governing body for the utilization of Medicaid and Medicare programs was indeed constitutional.

The American Association of Physicians and Surgeons had brought suit against the PSRO legislation charging it represented unconstitutional interference in the private practice of medicine.

However, the three-judge panel dismissed the suit ruling that the law "only provides standards for the dispensation of federal funds," thus upholding Congress' right to insure that federal funds are not over-utilized.

Despite the Chicago ruling, continued opposition to the PSRO amendment is expected. The May 14th issue of **Washington Report on Health Legislation** reported that 19 AMA-drafted amendments to the PSRO law have been submitted to both houses of Congress.

The report also noted that several legislators which it did not name have submitted proposals to repeal PSRO, but whether or not the Senate Finance and Claims and House Ways & Means Committee are expected to pursue changes in the law is open to question.

MALPRACTICE INSURANCE CAUSES CALIFORNIA DOCTORS TO WALK OUT

At midnight April 30, 4,000 doctors in the San Francisco area elected not to renew their medical malpractice insurance policies with Argonaut Insurance Co. of Menlo Park, California.

The result brought all but emergency surgery to a virtual standstill as doctors refused to pay increased rates which reached as high as 322 per cent.

Several days later a spokesman for San Francisco's anesthesiologists announced that the group would maintain their hard line against the skyrocketing rates.

Dr. Dan Walker, chairman of the anesthesia section of the San Francisco Medical Society is quoted as saying, "We are sorry for the inconvenience to the public and the economic hardship imposed on hospital employees, but once and for all this issue must be resolved."

Within a week, effects of the walkout were being felt as some 3,000 hospital workers in the area were laid off. Estimates of the number of anesthesiologists who were remaining off the job were between 165 and 250.

Dr. Hugh Vincent of the San Francisco Medical Society told the Associated Press that: "This is not a union action. Each individual is doing his own thing."

Donald Burns, State Business and Transportation Secretary and California's top insurance official told AP, "The result is that I am concerned that people are being thrown out of work, like orderlies and nurses. But this is a problem that the doctors created for themselves."

Argonaut reportedly was seeking increases from $5,377 to $18,164 per year for anesthesiologists and other high risk specialists. The increases were expected for some time as a number of insurance companies have been bailing out of medical malpractice coverage altogether in the last several years.

NWAHPC Studies Federal Regulations

The Northwestern Areawide Health Planning Council with the assistance of the Division of CHP and John Short and Associates, a consulting firm from Salt Lake City, has recently completed a study determining the impact of federal regulations on the operation of long-term care facilities in the area.

Such impact is the result of the facilities' participation in the federal Medicare and Medicaid programs which is essential to the operations of these facilities.

The study was prompted by concern over alleged inequities in the enforcement of federal regulations. Specifically, the contention is that the regulations governing staffing levels do not take into consideration small facilities such as those in rural Montana where there is an across-the-board manpower deficit.

Says Health Researcher Joanne Brothers, "Nobody questions the value of providing increased staff and services; but in a rural setting the added cost of recruitment and maintaining the additional health manpower is passed on to the consumer."

Brothers indicated that if the federal philosophy continues to require the increased staffing levels and services, then it would be economically difficult for the small long-term care facilities to comply with the regulations.

Brothers also mentioned that the state's moving developmentally disabled patients from the state institutions to the facilities has had an added impact on the nursing homes. "Nursing homes will have to provide services to this type of patient that just are not available right now," she added.

The Executive Board of the Areawide Council made the following recommendations to the federal government, the state survey agency, and the Montana Nursing

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Home Association after reviewing the report:

That the federal government in setting standards make geographic distinctions such as size of facility, available manpower and location.

That the federal government either provide additional financial assistance to rural providers to make implementation standards more feasible; relax some of the restrictions that are detrimental to small, rural long-term care facilities; and/or make it possible for the state survey agency (Montana State Department of Health and Environmental Sciences) to provide development models and assist in recruiting health manpower.

That a recruitment program for specialized manpower should be set up on a regional or state basis and the responsibility should lie with the state survey agency or the Montana Nursing Home Association.

That the federal agency responsible for training the survey agency should allow more time for training before the implementation of regulations. Also interpretive guidelines should be available to providers prior to implementation of the standards.

Concerning impacts of the developmentally disabled on long-term care facilities: Due to the significant impact this population has had, the recommendation is to require and implement group home regulations defining the requirements for homes presently providing services for only the developmentally disabled. Furthermore, the State should be required to announce its long-range plans for the developmentally disabled patients that are presently residing in long-term care facilities.

That the survey agency should place at least one surveyor in the region to expedite implementation and supply technical assistance to long-term care facilities to achieve compliance in standards.

That due to the cost of locating a nursing home within a hospital, review criteria and guidelines be developed to consider the feasibility of "co-location" when a facility is applying for such a designation.

HEALTH PLAN IMPLEMENTATION

The Environmental Health Committee is currently in the planning stages of developing a workshop which is designed to stimulate the implementation of the Environmental Health Plan included within the State Plan for Health.

Intended to bring together those key decision makers and implementors cited in the Environmental Health Section's 33 objectives, the workshop scheduled for September 25 and 26 will try and determine to what extent those involved in Environmental Health find the Plan to be a working tool.

Scheduled to take place over a two-day period in Helena, the first day will host a presentation of the Environmental Health Plan by Jon Tovson, author. That presentation will be followed by a discussion of the Plan. State and local officials will be asked if they perceive the plan to outline what they consider to be areas of concern in environmental heath.

The second day will deal with prioritizing areas of concern, defining roles and responsibilities within the environmental health field, and outlining courses of action.

Dave Stuart and Martha Dow of the Environmental Health Committee.

"The specific purposes of the workshop will be to arrive at a common understanding of and consensus on the Environmental Plan, agree upon priority areas of concern in environmental health, define roles within the implementation process, and agree upon and develop strategies to solve the problems so identified as priority areas," explained Martha Dow, Chairperson of the Committee.

At this point, one major concern of the Environmental Health Committee is the matter of funding for the workshop. A grant application was submitted to the Department of Health, Education and Welfare under the threat of deadline. However, no word of the application's status has been received as yet.

It is hoped that federal, state and locally-elected officials along with providers and consumers of health care, environmentalists, health professionals, and concerned citizens will attend the workshop.

Two professional facilitators from the State Extension Service at Montana State University, James DeBree and Robert Neils, will assist in the workshop.

Tentatively the workshop is to be held at the Travelodge in Helena on September 25-26. The Environmental Health Committee will be finalizing plans within the next month and a final, complete agenda will be disseminated at that time.

Those wishing more information on the workshop should write:
Environmental Health Committee
Comprehensive Health Planning Division
Department of Health and Environmental Sciences
Cogswell Building
Helena, Montana 59601.

Rural Health—

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federal programs aimed at increasing the number of physicians choosing a rural practice. However, he added that perhaps the rural needs could only be met by some form of compulsory medical service similar to a draft.

"If America is to enjoy its fair share of physicians, some kind of compulsary program — a doctor draft — will probably have to be enacted."

Margolis noted that both the AMA and American Association of Medical Colleges (AAMC) oppose the concept of a draft.

"They oppose this (concept) on the traditional grounds that voluntary schemes are always preferable to compulsary ones. But voluntary schemes thus far have solved nothing.

"Besides, why shouldn't distribution of our new doctors be considered a question of public policy? It is the taxpayer, after all, who educates doctors by footing at least half the medical schools' bills. Over the past decade federal spending for health manpower programs has increased from $65 million a year to $536 million a year," he said. He further cited the concept of regionalization of services as adding to the problems of rural health care in that they would force small rural hospitals out of existence.

"To many rural Americans the all too familiar look; it bears a striking resemblance to notions that for half a century have spelled the decline of small towns: not only the regionalization of hospitals, but also the consolidation of schools, the abandonment of railroads, the mapping of highways so as to bypass small towns, and the denial of subsidies to communities unable to establish their credentals as 'growth centers.' These are among the historic policies that will soon have to be reversed if small town citizens are to win an equitable footing in the nation's mainstream; if rural America, that is, is ever to regain its health," Margolis said.

Under Observation

by Dennis Taylor

The specter of National Health Insurance is once again rearing its head on the Congressional horizon. Like a perennial mirage, NHI is touted as being just around the corner. "NHI, not if, but when," goes the now all too familiar battle cry. As escalating health care costs continue unabated and the realities of recession close in, the 94th Congress may indeed be forced to act this session to establish a system of National Health Insurance which will provide all residents of this nation protection against the economic catastrophe of illness. Several key prepatory pieces of the NHI puzzle are beginning to fall into place as PL 93-641, the National Health Planning and Resources Development Act, and the Professional Standards Review Organization law begin to set up mechanisms for cost containment, systems rationalization, and some measure of quality control. What is missing, however, is the most important preparation for NHI — the state response — a comprehensive system of local public health.

If NHI is going to work, it must be supplemented and predated by a system that insures the promotion of optimum health and the prevention of illness. The National Health Insurance proposals, which thus far have been advanced, consist primarily of a method for paying sickness costs and amount to only a financial mechanism to maintain the current chaos of our health care delivery system. Dr. C. Arden Miller, President of the American Public Health Association, thinks the problem is worsening. In a recent column he states, "During most of this century a patchwork of public health programs has developed, not to replace the marketplace of health care, but to compensate for its deficiencies. These deficiencies are still there but the compensatory patchwork, never adequate to the need, is being torn away."

Montana's patchwork of local public health has always been threadbare and fragmented. Efforts of the two-year HJR 18 Study Committee outlined the problem and offered a skeleton of workable recommendations to begin to implement a system of local health promotion for Montana. In the last Legislature, HB 478, a proposal introduced by Rep. John Driscoll (D-Hamilton) which would have gone a long way towards the goal of insuring a minimum level of public health services for all Montanans, fell on deaf ears in the House Public Health, Welfare and Safety Committee.

The substance of health promotion and health protection through enhanced local public health capacity in Montana remains wanting. Its significance is yet to be fully understood by health policy decision makers in Montana. Our situation may not be as dire as states such as Mississippi, but it is certainly not as good as some of our sister states, such as Idaho, where the framework for local public health has been enacted and numerous state legislators have surfaced as informed, aggressive and articulate advocates of public health policy initiatives.

Montana has yet to produce a single legislator with prime interest in health, much less the requisite core of health policy advocates necessary to prepare for and respond to the requirements of any national health insurance scheme with direct and cohesive action.

Once again, Montana is taking the "ostrich approach" to problem solving in the health area, feeling that if you bury your head in the sand the problem will go away. The **Montana State Plan for Health** calls for the adoption of "the concept of regionalization for the delivery of public health services" and for "the gradual building of an integrated public health program that will provide comprehensive public health services of optimum quality equally available and accessible to all Montanans." This study, too, threatens to go with the way of the HJR 18 Study, facing little chances for implementation in the near future due to the lack of serious consideration by Montana policy decision makers — another study to gather dust on the library shelf.

What needs to be done and needs to be done now, is to begin gathering momentum for the next legislature with a strong and resolute plan of action that will insure a long overdue system of health promotion in Montana — local public health. Time is running out for the preparation for NHI. The puzzle begins to take shape. Let's not let Montana be left with several key pieces missing. The time for local public health for all Montanans is now.

HEALTH LEGISLATION SUMMARY
44th Montana Legislature

The following is a summarization of how key health-related bills fared in the 1975 Montana Legislature.

HB 29 — Gerke. Would require that 5 members of the Board of Health and Environmental Sciences be nonprofessionals and the other two members be from health-related professions. (Signed by the Governor, 4/8/75)

HB 42 — Luebeck, et al. Would require prescription price posting and quotations and the listing of related services. (House, Killed in Business and Industry, 1/28/75)

HB 45 — Gunderson, et al. Would provide for the licensure and regulation of radiologic technologists under the Department of Professional and Occupational Licensing. Creates a Board of Radiologic Technologists. (Signed by Governor, 4/9/75)

House of Representatives — 44th Legislature

HB 60 — Palmer, et al. Would appropriate $40,000 for family planning services throughout the state and provides that no minor could be served without parental consent. (Signed by Governor 4/8/75)

HB 72 — Jack Moore, et al. Would provide for certification of emergency medical technicians by the Board of Medical Examiners. Provides for the acts they may perform and limits their liability. (Signed by the Governor, 3/19/75)

HB 73 — Moore, et al. Provides for the certification of physicians' assistants (PA) by the Board of Medical Examiners in accordance with rules and regulations of said Board; provides that no practitioner shall supervise more than one PA; and limits the practice of a PA to his practitioner's place of business or physical presence. (Died when four conference committees could not reach a compromise.)

HB 119 — Johnson, et al. Would appropriate one hundred thousand dollars ($100,000) to the Department of Health and Environmental Sciences, so that Department can in turn contract with the University of Montana for five studies on the adverse health effect of air pollution on Missoula Valley residents. (House, Killed in Appropriations, 3/20/75)

HB 123 — Murphy, Dassinger. Would allow the Board of Medical Examiners to waive personal appearances before the Board prior to license issuing. (Senate, Indefinitely postponed on Second Reading, 3/5/75)

HB 124 — Murphy. Would allow the Board of Medical Examiners to revoke or suspend a license to practice medicine and surgery when the holder of the license has had his license revoked or suspended by another jurisdiction. (Signed by Governor, 3/18/75)

HB 129 — Brand, Menahan. Would regulate odoriferous establishments (feed lots and poultry), defines public nuisances and authorizes the Department of Health and Environmental Sciences to make rules. (House, Killed on Second Reading, 2/25/75)

HB 133 — South. Would require all counties to participate in the cost of regional mental health center programs in Montana. (Died in Senate Public Health, Welfare and Safety Committee.)

HB 170 — Federico. Would repeal the Montana contraceptive law thereby removing all restrictions on sale. (House, Killed in Public Health, 2/8/75)

HB 171 — Federico. Would authorize counties to legalize prostitution outside of incorporated towns and cities. (House, Killed in Public Health, 2/8/75)

HB 174 — Lockrem. Would provide a state income tax credit to doctors and dentists who practice in Montana cities and towns with less than 10,000 population. (House, Killed in Judiciary, 2/21/75)

HB 186 — Huennekens. Would require any person conducting an industrial or commercial process that discharges designated critical materials into the air and water to file annual reports on the source and amount of these materials. The Department of Health and Environmental Sciences shall investigate the reports. The Attorney General shall enforce the act. (House, Died in Natural Resources for Lack of Transmittal.)

HB 201 — Hager, et al. Would authorize a veterans nursing home and hospital at Billings. It shall be constructed and run to obtain federal monies. Would require an outlay of State funds. (House, Killed in Appropriations, 4/17/75)

HB 239 — Conroy, et al. Would control the distribution of sample drugs, limiting them to practitioners of medicine, dentistry, and podiatry upon their written request. (Senate, Indefinitely postponed on Second Reading, 3/21/75)

HB 256 — Finley. Would permit citizens with medically acknowledged terminal conditions to die if they so choose. Would allow anyone after filing a document of declaration to die. Provides for nonliability on the part of doctors and nurses. (House, Killed in Public Health, 2/6/75)

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Health Legislation—

continued

HB 262 — Palmer, Federico. Would enact the Uniform Residential Landlord and Tenant Act which equalizes the rights and duties of landlords and tenants in rented dwellings. (Senate, Killed on Third Reading as Amended, 4/3/75)

HB 296 — Federico, Holmes. Would require anyone operating a foster home or institution where seven (7) or fewer people live and are cared for to obtain a license from the Department of Health and Environmental Sciences. (House, Died in Public Health for Lack of Transmittal.)

HB 326 — Conroy, et al. Would delete the wording that allows prescriptions to be refilled when no limitation is provided on the prescription. Also would provide punishment for persons found guilty of forging prescriptions. (Senate, Killed in Public Health, 3/19/75)

HB 340 — Sheldon, Bradley, et al. Would authorize each state agency to adopt rules imposing a fee to be paid by an applicant for a lease, permit, contract, license or certification when an agency is required to compile an environmental impact statement. (Signed by Governor, 4/8/75)

HB 342 — Gerke, Driscoll, Bardanouve, et al. Housing Act of 1975. Would create a Board of Housing, provides powers and duties relating to financing to assist private enterprise and governmental agencies to meet housing needs. (Signed by Governor, 4/16/75)

HB 351 — Holmes, et al. Would provide for a penalty for smoking in enclosed public places that are posted as non-smoking areas. (Senate, Killed on Third Reading as Amended, 3/24/75)

HB 352 — Dussault, et al. Would make unlawful the use of junked motor vehicles for flood control of a stream or for reinforcement of the banks of a stream. (Signed by Governor, 3/24/75)

HB 353 — Dussault. Would provide for community-based services for the developmentally disabled. Would make the Department of Social and Rehabilitation Services the responsible agency. (Signed by Governor, 4/3/75)

HB 356 — Dussault, Holmes. Provides for a hospital and hospital-related facility annual licensing fee based on the number of beds; 20 beds or less, $20; $1 per bed over 20 beds. (Signed by Governor, 4/7/75)

HB 357 — Dussault, Holmes. Would provide staggered terms for the members of the Board of Nursing Home Administrators. (Signed by Governor, 3/19/75)

HB 360 — Murphy. Would allow the use of quarter and semester hours in computing the four years' instruction required to obtain a license to practice podiatry. Also provides for licensure if the applicant has passed the National Podiatry Board Examination. (Signed by Governor, 3/19/75)

HB 370 — Meloy (By Request of SDHES). Would revise the water pollution control laws to conform with federal requirements, to improve enforcement procedures and to provide for user charges for industrial and other users of public sewage treatment systems. (Signed by Governor, 4/16/75)

HB 387 — Rasmussen. Would prevent physicians from delegating their exemption from the provisions of the optometric law to any non-physician. (House, Died in Public Health for Lack of Transmittal.)

HB 414 — Rasmussen. Would establish an interagency committee with members from the Department of Health and Environmental Sciences, Social and Rehabilitation Services, and Institutions. The Committee shall establish a program of problem pregnancy counseling and for the training of counselors. (Senate, Killed in Public Health, 3/19/75)

HB 425 — Ellis, et al. Would establish a program of litter control. Provides for the Department of Natural Resources and Conservation as enforcing agency. (House, Died in Natural Resources for Lack of Transmittal.)

HB 434 — Lory, Ellis. Would authorize the Department of Social and Rehabilitation Services to make rules relating to care of "medically needy" and to establish the income level for such persons but not in excess of 300% of the general medical assistance income level. (Signed by Governor, 4/10/75)

HB 467 — Menahan, Brand. Would allow certain masters level psychologists to obtain a licensed private practice in Montana. (House, Killed in Public Health, 2/21/75)

HB 471 — Kimble. Would establish the county attorney as the legal advisor for county and city boards of health. Also widens the legal powers of local boards by increasing fines, granting injunctive powers and by declaring each day of violation a separate offense. (Signed by Governor, 4/7/75)

HB 478 — Driscoll. Would require the Department of Health and Environmental Sciences to develop programs to insure a statewide minimum of public health services. (House, Died in Public Health for Lack of Transmittal.)

HB 509 — Bengston, Finley. Would modify the Nursing Practice Act to permit "nursing diagnosis," would expand the authority of the Board of Nursing to approve continuing education programs related to health care. (Signed by Governor, 3/27/75)

HB 515 — Holmes, et al. Would establish an emergency services information officer in each county department of public welfare. This individual shall act as a referral source for people seeking help. (House, Killed on Second Reading, 2/11/75)

HB 517 — Wolfe, Holmes. Would provide for licensure of home health agencies by the Department of Health and Environmental Sciences. (Vetoed by Governor, 4/11/75)

HB 556 — Sloan, et al. Would create a forensic laboratory within the Department of Health and Environmental Sciences. Also appropriates forty-five thousand nine

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hundred forty-two dollars ($45,942) to gain federal matching funds. (House, Killed in Appropriations, 3/20/75)

HB 557 — Driscoll, Meloy. Would provide $200,000 for feasibility study to determine resource recovery value in solid waste; reduces motor vehicle title transfer from $4 to $2. (Signed by Governor)

HB 558 — Driscoll (By Request of SDHES). Would appropriate $250,000 to the Department of Health and Environmental Sciences for a solid waste disposal study. (House, Killed in Appropriations, 4/17/75)

HB 565 — Manuel. Would allow hospital districts to choose the number of trustees by setting that information forward in the district by-laws. (Signed by Governor, 4/7/75)

HB 577 — Kemmis, et al. Would remove all qualifications required for Director of the Department of Health and Environmental Sciences. Currently, the Director must be an MD have one year graduate training in public health and two years' experience as a health officer. (House, Killed in Public Health, 2/25/75)

HB 582 — Kvaalen, et al. Would appropriate four million two hundred and fifty thousand dollars ($4,250,000) to construct a regional health care facility at Sidney. (House, Killed in Appropriations, 4/17/75)

HB 609 — Lien, Fabrega. Would create an ad hoc medical review board which will act as an appeal board in conjunction with the Board of Medical Examiners. (House, Died in Public Health for Lack of Transmittal.)

HB 640 — Murphy, et al. Would create the office of patient's attorney within the Department of Institutions. The office would provide legal aid to patients in any of Montana's mental health care institutions. (Senate, Killed in Judiciary, 3/18/75)

HB 657 — Wood, et al. Would prohibit the consumption of alcoholic beverages and the possession of open containers in or on motor vehicles while upon public highways. (Died in House, Appropriations)

HB 668 — Holmes. Would appropriate fifty thousand dollars ($50,000) to carry out the training of problem pregnancy counselors under the program outlined in HB 414. (House, Killed in Appropria- 3/20/75)

HB 671 — Dussault. Would allow the Department of Social and Rehabilitation Services to contract with licensed profit health corporations to provide services to developmentally disabled individuals. (Signed by Governor, 4/10/75)

HB 699 — Bardanouve, Gerke, Mercer. Would consolidate and transfer all drug and alcohol-related programs to the Department of Institutions. (Signed by Governor, 4/7/75)

SB 37 — Norman, Brown (By Request of SDHES). Would provide for determination and collection of civil penalties under the Clean Air Act. (Signed by Governor, 3/24/75)

SB 38 — Norman, Brown (By Request of SDHES). Would establish procedures for maintaining the confidentiality of trade secrets involved in air pollution control proceedings, provides that emission data will be considered confidential for the purpose of the Clean Air Act. (Signed by Governor, 4/7/75)

SB 39 — Norman, Brown (By Request of SDHES). Provides methods for obtaining permits from the Department of Health and Environmental Sciences for the construction, installation, alteration, or use of equipment or facilities which directly or indirectly contribute to air pollution or which contribute to the abatement of air pollution. (Signed by Governor, 3/31/75)

SB 61 — Fasbender, et al. Would remove criminal penalties for alcoholism and abuse of alcohol. Would allow the police to detain a publicly drunk person only for his own protection. (Signed by the Governor, 4/14/75)

SB 73 — Roberts. Would create an emergency medical service's account to provide for more local emergency medical programs. The Department of Health and Environmental Sciences will control the distribution of the earmarked funds. (Senate, Killed in Finance and Claims, 2/22/75)

SB 128 — Blaylock. Would require the use of reusable beverage containers for beer and soft drinks. (Senate, Killed in Natural Resources and Fish and Game, 2/11/75)

SB 182 — Lee, et al. Would provide long-term care facilities immunity when providing blood transfusion services. (Signed by Governor, 3/19/75)

SB 190 — Lynch. Would provide individual members of peer review and professional standards review committees with non-liability. (Signed by Governor, 4/3/75)

SB 216 — Norman. Would authorize the Department of Social and Rehabilitation Services to offer protective services to aged or disabled adults. (Signed by Governor, 4/3/75)

SB 217 — Norman. Would authorize the Department of Social and Rehabilitation Services to license adult foster family care homes where three (3) or fewer aged or disabled adults reside and are cared for. (Signed by Governor, 4/8/75)

SB 316 — Lee. Would require the issuance of a certificate of need by the Department of Health and Environmental Sciences for construction, modernization of hospital or hospital-related facility. (Signed by Governor, 4/16/75)

SB 322 — Lee, et al. Would allow "out-patient facilities B" (those not in a hospital building) to have observation beds. (Senate, Killed in Public Health, 2/17/75)

SB 329 — Colberg, et al. Would authorize the Department of Health and Environmental Sciences to increase the license fee for hotels, motels, tourist homes, retirement homes and rooming houses from ten dollars ($10) annually to thirty dollars ($30). The Department will in turn annually pay to local boards of health twenty dollars ($20) for each establishment within the jurisdiction of that local board. (Signed by Governor)

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Dr. Pat McCarthy

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WARNING: The Surgeon General has determined that cigarette smoking is hazardous to your health.

Perhaps somewhat ironically, even those who are health professionals do not all heed the warnings of the Surgeon General. Photos taken at a recent meeting of the State Advisory Council to Comprehensive Health Planning reveal that a good number of Council members, CHP personnel, and guests still contribute to the atmospheric conditions of those "smoke-filled rooms."

Council Member Anita Richards

Health Legislation—

SB 330 — Colberg, et al. Would authorize the Department of Health and Environmental Sciences to increase the annual license fee for tourist campgrounds and trailer courts from ten dollars ($10) to thirty dollars ($30). The Department will in turn annually pay to local boards of health twenty dollars ($20) for each establishment within the jurisdiction of that local board. (Signed by Governor)

SB 331 — Norman, et al. Would require that the Board of Pharmacists waive the registration requirement for all practitioners and pharmacies under the Dangerous Drug Act. (Signed by Governor, 4/7/75)

SB 332 — Graham, Mathers, et al. Would revise the appointment of members of the Environmental Quality Council, provides terms and compensation. (House, Killed in Natural Resources, 4/3/75)

SB 367 — Colberg, et al. Would authorize the Department of Health and Environmental Sciences to increase annual license fee for food establishments from ten dollars ($10) to thirty dollars ($30). The Department will in turn annually pay to local boards of health twenty ($20) for each establishment within the jurisdiction of that local board. (Signed by Governor)

SB 376 — Watt, Brown. Would provide that nursing homes would be licensed and regulated by the Public Service Commission rather than the Department of Health and Environmental Sciences. (Senate, Killed in Public Health, 2/19/75)

SB 377 — Towe, et al. Would recodify the laws concerning the treatment of the mentally ill. Also creates a medical disabilities board of visitors to inspect and report on the mental health facilities in Montana. (Signed by Governor, 4/18/75)

SB 387 — Norman, et al. Would regulate nonprofit health service corporations (Blue Cross and Blue Shield) in the State of Montana. (Signed by Governor, 4/8/75)

SB 388 — Towe. Would insure the human rights of the developmentally disabled. Also provides for levels and types of treatment. (Signed by Governor, 4/18/75)